California Rural Health Policy Council

1998 Report on Collaboration and Innovation in Rural Health

Part I - March 1996 to March 1998

California's Rural Health Policy Council:

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Table of Contents

INTRODUCTION

- **Background**

  Rural areas encompass 13% of California's population and 80% of its geography. Recognizing that rural areas of California were indeed different from urban metropolitan areas and required targeted attention, Assembly Bill 911 (Chapter 305/1995) was passed by the Legislature and signed by the Governor in September 1995. This landmark rural health legislation directed that a State Office of Rural Health or an "alternative organizational structure" be established as the focal point on rural health policy within State government. On March 8, 1996, Health and Welfare Agency Secretary Sandra R. Smoley, R.N., established the Rural Health Policy Council, consisting of the directors of the Department of Health Services, the Office of Statewide Health Planning and Development, the Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, and the Department of Mental Health. The Policy Council then proceeded to carry out the various actions detailed in AB 911, in order to coordinate rural health policy in California.

- **Purpose of this Report**

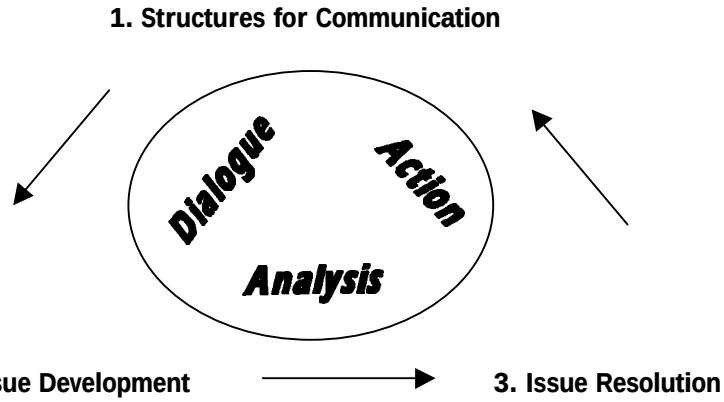
  Pursuant also to AB 911, on May 1, 1996, the Rural Health Policy Council submitted its *1996 Report on Rural Health* as a strategic plan to address rural health needs. The *1996 Report* documented many of the issues and needs of rural health care delivery in California, and listed many actions underway in the Policy Council, as well as various State agencies. This 1998 report will document progress on those actions and report on planned activities for the future. Part I, contained in this volume, will report on progress made in completing the planned actions as reported in May 1996 and on the additional activities undertaken through March 1998. Part II, to be issued in the future, will report on anticipated actions through 1998 and beyond.

  The challenges for rural health have not disappeared in the past two years, and indeed, many remain to be solved today. However, as this first volume describes, significant efforts are underway to address identified problems, through a process of State interagency, county and local health provider collaboration. Gratifying progress has been made in the consistency, frequency and response time of the communication system between State agencies and the local county and health providers.

  But, beyond the continuing dialogue and solving of current problems, the Policy Council envisions changes in how State agencies will conduct business in rural areas. It has adopted a Vision, Mission, and Project Workplan (included in the last section of this report) to guide the work of the Policy Council into the future, and to bring as many of these transformational ideas to reality as possible.

EXECUTIVE SUMMARY

- **Overview of the Process**



The process for the Rural Health Policy Council's efforts in working with rural health issues and communities during this report period can be characterized as having the following three phases: developing structures for communication, developing issues, and resolving the identified issues. Each phase can be further characterized by a corresponding activity during that phase – dialogue, analysis and action -- that led to the next phase. This does not imply a strictly linear process. In fact, all three of these activities were occurring somewhat simultaneously. However, the use of dialogue, objective analysis and collaborative efforts characterize the operating approach adopted by the Policy Council in its work.

- **Major Accomplishments**

  - ***$6.9 million in Grants***: The Rural Health Policy Council, assisted by staff from the Department of Health Services and the Office of Statewide Health Planning, conducted a competitive grant process for Fiscal Years (FY) 1996-97 and 1997-98. These grants provided funds to a variety of providers in different settings including hospitals, clinics, long-term care facilities, and healthcare delivery networks. Grants totaling $5 million for FY 1996-97 and $1.903 million for FY 1997-98 were used by providers to establish new or to expand existing innovative healthcare delivery systems or programs.

  - ***Public Meeting and Hearings***: Public meetings and hearings were held throughout rural California by the Policy Council and the Interdepartmental Rural Health Coordinating Committee. Five public meetings were held in 1996; eight public meetings took place in 1997. These meetings were held in rural areas, including Fish Camp, Indio, Hollister, Quincy, Porterville, and El Centro. Often they were held in conjunction with other organizations' annual meetings to ensure broad-based attendance.

- ***Vision, Mission and Project Workplan***: The Policy Council worked with the Coordinating Committee and gathered public testimony to adopt a Vision, Mission, and Project Workplan. The Project Workplan was further prioritized by the Policy Council, in considering discussion at hearings and other meetings.

- ***Foundation Support***: The Policy Council works with a consortia of private, nonprofit charitable funders to share rural plans and strategies, such that both public and private organizations can plan complementary efforts.

- ***Issue Tracking***: In addition to holding public meetings, the Coordinating Committee established a process for issue tracking and response. The RHPC Office developed and maintains a database of issues and service requests from constituents. The issue or service request is tracked from its introduction, to the responsible department, and through to its resolution.

- ***Liaison Visits***: The Rural Health Programs Liaison was visible in rural California by visiting rural communities to meet with local leaders, health care providers and community groups. The Liaison attended and participated in a wide variety of rural health-related associations, meetings, workshops, conferences and training activities, throughout the State and nationally.

- ***Facilitated Assistance***: The Liaison facilitated bringing those with expertise in a given area together with those needing assistance. For example, the California Department of Developmental Services (DDS) needed assistance with telehealth/telemedicine technology and planning. The Liaison coordinated a meeting where the Director of the Telehealth/Telemedicine Resource Center at the California Healthcare Association met with DDS to advise them on ways to coordinate telehealth/telemedicine communication among their twenty-four regional centers.

- ***Information Resources***: The RHPC Office furnished information to health care providers, associations, counties, community based organizations, universities and residents via a variety of methods, including:

    - a toll-free telephone information line, a newsletter, provider site visits, attendance and presentations at trade association and various county committee and council meetings;

    - a database of over 1,600 individuals from rural associations, hospitals, clinics, long-term care facilities, councils, county governments, and private and public foundations, which can provide database extracts to groups for directed mailings; and,

    - a site on the Internet that features linkages to the websites of other public and private rural funding opportunities, rural health associations and organizations, federal rural health-related offices, California state agencies and the Legislature,

health policy and education sites, telehealth/telemedicine projects and resource centers.

- ***Health Workforce***: The RHPC Office developed and maintains a website for the "Jobs Available Program", which is affiliated with the National Rural Recruitment and Retention Program (3R-Net) at the University of Wisconsin. The Jobs Available Program has listed over 330 recruitment advertisements in various types of provider settings. The Office also participated and presented at the Recruitment and Retention Conference sponsored by the North Coast Clinics Network.

- ***New Services***: The RHPC Office conducted a statewide survey in July 1997 to gather information from providers on how the Policy Council can better serve their needs. Information was collected on the following subject areas: the level of service provided by the RHPC Office staff; the timeliness and convenience of the public meetings; the information contained in and timeliness of the newsletter; the usefulness of the "Jobs Available Program;" the benefits of the Policy Council's website; and any additional services/information constituents would like the RHPC Office to provide.

- ***Coordination across Organizations***: The RHPC Office staff coordinated activities by attending and participating through presentations and discussion in the monthly meetings of various rural health-related associations. These included the Small Counties Committee, a sub-committee of County Health Executives Association of California (CHEAC), the County Medical Services Program (CMSP) Planning Committee and the CMSP Board of Governors meeting.

- **Next Steps**

  The Policy Council has adopted a Vision, Mission, and Project Workplan for rural health in California. The Project Workplan addresses the highest priority problems facing the rural health field today, as determined by public hearing testimony and other input solicited by the Policy Council. To the extent possible in the coming months, the workplan topics will be addressed by the Coordinating Committee through individual action plans.

  The Policy Council will publish Part II of this *1998 Report: Future Actions*, which will include the individual project action plans, selected issue papers, and performance measures. These future actions will be undertaken with the help of the many rural health constituents in the State, and in the same cooperative spirit established in the first two years of Policy Council activity.

STRUCTURES FOR COMMUNICATION

The RHPC's *1996 Report on Rural Health* identified three fundamental issues confronting rural health communities in communications concerning administration of rural health care programs, as follows:

- A need for a defined focal point at the state level for development of a broad-based, proactive statewide rural health policy agenda;

- A need for a defined process to promote coordinated policies and programmatic approaches between and among State departments to address specific health care service problems facing rural communities; and,

- A need for a clearly defined point of contact at the state level for health care professionals and members of rural communities to raise program-specific and cross program issues that affect the delivery of state and federal health care programs.

To address these issues, a new organizational structure was put in place and has functioned well. It consists of the following:

1. **Rural Health Policy Council**
   In March 1996, the Secretary of California's Health and Welfare Agency created the Rural Health Policy Council (Policy Council) to promote and support collaboration, communication and networking among State agencies, rural constituency organizations and rural providers. The members are the directors of the following five departments within the Health and Welfare Agency:

   Department of Health Services
   Office of Statewide Health Planning and Development
   Department of Alcohol and Drug Programs
   Emergency Medical Services Authority
   Department of Mental Health

   The role of the Policy Council is:
   - to formulate and establish rural health policy for the State of California;
   - to provide a focal point for discussion of rural health policy issues within the Health and Welfare Agency;
   - to receive suggestions and recommendations from rural health constituencies; and,
   - to improve services provided to rural health providers.

2. **Interdepartmental Rural Health Coordinating Committee**
   The Policy Council created an Interdepartmental Rural Health Coordinating Committee (Coordinating Committee) to study issues, make recommendations and accomplish the goals adopted by the Policy Council. The Coordinating Committee is composed of 15 managers from major state health programs serving rural communities, and is chaired by the Rural Health Programs Liaison. Issues that cannot be resolved at the Coordinating Committee level are elevated to the Policy Council for

consideration and appropriate action. For a listing of departments and programs currently represented on the Coordinating Committee, please refer to Appendix 2.

The role of the Coordinating Committee is:

- to receive, discuss and resolve rural health issues that involve more than one department represented on the Policy Council;
- to receive comments from rural health constituencies; and,
- to improve services provided to rural health providers and communities through promoting and practicing collaboration, cooperation, communication and networking among State agencies, rural constituency associations, rural providers, and the Rural Health Programs Liaison.

3. Rural Health Programs Liaison

The Rural Health Programs Liaison (Liaison) serves as principal staff to the Policy Council, the director members, and the Health and Welfare Agency on rural health issues. The Liaison serves as the head of the RHPC Office and functions as the link between the Policy Council, the Coordinating Committee, providers, counties, associations, and rural constituents to address rural health issues. The Liaison facilitates cooperation and communication between entities to solve distinct problems and/or to promote relationships.

The role of the Rural Health Programs Liaison is:

- to facilitate communication between rural constituencies and State department program contacts;
- to be accessible and visible in rural areas throughout California by visiting health providers and communities to hear their concerns first hand;
- to serve as chairperson of the Coordinating Committee, defining the agenda topics for Policy Council and Coordinating Committee meetings; and,
- to convene meetings of both the Policy Council and the Coordinating Committee, presenting issues for their consideration and appropriate action.

4. Rural Health Policy Council Office

The Rural Health Policy Council Office (RHPC Office) was created from resources redirect from within the Policy Council departments. The RHPC Office is organizationally located within the Health and Welfare Agency, and currently has five full-time staff members.

The role of the RHPC Office is:

- to work directly with rural health care providers, associations, clinics, hospitals, counties, and other non-profit organizations to collaborate, communicate, cooperate, and coordinate on rural health issues and facilitate policy change;
- to act as an information exchange focal point for providers and citizens in rural areas, communicating through multiple media, including the following:
    1. an extensive RHPC website on the Internet (www.ruralhealth.ca.gov), which provides information on the Policy Council, links to many other rural health resources, the funding clearinghouse and the “Jobs Available” service;

2. a newsletter, “Rural Health Newscast”, which is published eight times annually and sent to over 1,600 rural health providers, clinics, hospitals, provider networks, county health officials, industry associations and other interested parties statewide and nationally; and,
3. a toll-free telephone number for California constituents to call for information and referrals.

- to administer and maintain the “Jobs Available” service on the Internet through which health care providers can advertise, at no cost, all types of health-related positions available in rural areas statewide;
- to administer and maintain a “Funding Clearinghouse” service on the Internet, which lists funding opportunities available to providers in rural areas from federal, State and private foundations;
- to coordinate locations and agendas for rural-focused meetings, seminars, workshops and conferences with other organizations; and,
- to provide administrative staff support to the Policy Council and the Coordinating Committee, including scheduling, planning, and preparing the agendas and all supporting materials for their public and internal meetings.

ISSUE DEVELOPMENT PROCESS

- **Overview:** The following list of rural health policy issues was identified in the RHPC's *1996 Report on Rural Health*. During the past two years, this initial list has been further developed through gathering testimony at public hearings held in rural California locations, and through a system of issue and service request tracking established by the Coordinating Committee and maintained by the RHPC Office. The issues have also expanded to include recent changes in federal law, the State's Healthy Families Program, and the RHPC rural health small service and rural hospital grants. Taken together, these issues form the basis for the major topics adopted by the Policy Council in its Project Workplan, found further in this report.

- **Issue Summary**

1. **State leadership and coordination.**
   There is a need for coordinated planning and policy development for rural health between State agencies, public and private providers.

2. **Funding and reimbursement.**
   Rural California has a fragile health care infrastructure and survival of existing providers depends on the financial resources available to meet operational needs and capital requirements. Rural providers, many of whose patients are financially sponsored by government programs, are at risk when changes are made in the scope of benefits and reimbursement rates.

3. **Data systems.**
   Many rural areas lack the technical expertise and resources to improve and coordinate their local data collection activities, which are necessary for well-targeted health planning, program development, and resource development.

4. **Access to health services.**
   The lack of primary care and preventive services in the community and access to drug abuse, mental health and specialty services remain significant barriers in rural areas.

5. **Availability of health services and telemedicine linkages among rural and urban based providers.**
   Advanced communications technology linking rural areas to larger centers holds great potential for access to specialty expertise, clinical consultation, and continuing education for health professionals but as yet has not been utilized to any great extent.

6. **Professional development, workforce supply and retention.**
   A chronic problem in rural areas is the recruitment and retention of needed health professionals.

7. **Managed care.**
Most rural health communities lack the resources and/or expertise to make the transition from present practices to managed care, and to make other adaptations that may be necessary in the rapidly changing health care market place.

8. **Network development.**
The development of regional networks and collaborative efforts to make optimum use of available health care resources is recognized to be especially useful in rural areas, but will need assistance from State departments and technical support to accomplish.

9. **Regulation and licensing flexibility for rural facilities and consistent interpretation of regulations and statute among state enforcement staff.**
Rural providers need state enforcement agencies that recognize their unique challenges and abilities, acknowledge that rural requirements may be different from urban, and work with them in a helpful, flexible, and responsive manner.

10. **Emergency medical services and transportation.**
Weather, travel conditions, geographic remoteness, and lack of public transportation contribute to the challenges faced by residents of rural areas seeking routine healthcare. These problems are greatly magnified when there is need of emergency care. They demand coordinated plans for maintaining hospital emergency services, ambulance transport and air evacuation capability, and will require state level assistance.

ISSUE RESOLUTION PROCESS

- **Overview:** Once issues have been identified and prioritized, the Policy Council has directed the Coordinating Committee to undertake projects that will result in recommended changes that improve the current situation. The Secretary's expectation is that the Policy Council departments can change policy and procedures under their authority, and recommend changes to State or federal regulations and law, where needed. Most frequently, it is anticipated that the Policy Council departments will find ways to coordinate their policies, so that the administrative burden on rural providers is reduced.

  Another of the legislative directives is to have a clearly defined point of contact at the State level for rural health care providers and communities. Much of the first two years' efforts have been in establishing effective and accessible points of contact. Systems have been developed so that questions from rural providers are responded to promptly, and issues are directed to the appropriate departments for response.

- **Detailed Report on Accomplishments by Issue Category**

  During the report period, the issues were summarized and actions tracked according to the six categories shown below:

  I. State Leadership through Interagency Collaboration

  II. Funding and Reimbursement

  III. Data Systems

  IV. Availability and Accessibility of Workforce Services

  V. Network Development and Managed Care

  VI. State Regulation and Procedures Facilitation

  Individual activities are reported in detail on the following chart. (Activities originally reported in the *1996 Report on Rural Health* are shown in the first column; actions in the middle column have occurred since the *1996 Report*.)

ACCOMPLISHMENTS BY ISSUE CATEGORY

March 1996 to March 1998

I. STATE LEADERSHIP THROUGH INTERAGENCY COLLABORATION

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
1. HWA Secretary established an alternative organization structure composed of RHPC, IRHCC, a Rural Health Programs Liaison and RHPC Office.	*Proposed FY 1998-99 Governor's Budget includes ongoing funding for 4 positions in RHPC Office. Fifth position currently on 2-year loan from ADP.*	RHPC, IRHCC and RH Programs Liaison continue as established. BCP pending legislative approval for FY 1998-99 budget.
2. Appointed individual as RH Programs Liaison.		Original appointee continues to serve.
3. Held RHPC Public Meetings.		Held 3 meetings in 1996. Held 4 meetings in 1997.
4. Held RHPC Internal Meetings.		Held monthly meetings in 1996. Held monthly meetings in 1997.
5. Held IRHCC Public Meetings.		Held 2 meetings in 1996. Held 4 meetings in 1997.
6. Held IRHCC Internal Meetings.		Held monthly meetings in 1996. Held monthly meetings in 1997.
7. Expanded membership on IRHCC to Dept. of Social Services and Dept. of Community Services and Development.		Completed.
8. RH Programs Liaison established contacts with statewide rural and health associations:		
• Rural Health Constituent Database		Database designed and established; contains approximately 1,600 entries.

I. STATE LEADERSHIP THROUGH INTERAGENCY COLLABORATION

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
• Toll-free phone number (1-800-237-4492)		Installed and operating; receives approximately 12 calls per day.
• Site visits		Over 30 provider visits made in 1996; over 40 made in 1997; and 14 to date in 1998.
• Constituent Satisfaction Survey		Designed and completed; results implemented, incorporated into other action plans and widely circulated.
• RHPC Office brochure		Designed and completed; being widely distributed.
• Association meeting attendance and presentations		Networking and collaborating with 30 organizations. Ongoing presentations made by RH Programs Liaison and RHPC Office staff on RHPC activities.
9. RH Programs Liaison, DHS and OSHPD participated on Planning Committee for CA State Rural Health Association.		Planning phase completed. Association formed; Board seated in June 1997. RH Programs Liaison elected to Board.
10. Fact sheets on rural programs developed with DHS & OSHPD through its Rural Health Service Center.		Completed, distributed and in use by RHPC.
11. Encouraged innovative responses through communication and participation on committees:		

I. STATE LEADERSHIP THROUGH INTERAGENCY COLLABORATION

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
• RHPC Vision/Mission/Workplan		Updated statements adopted by RHPC after public review and comments gathered by RHPC, IRHCC, and RH Programs Liaison.
• Developing Rural Integrated Systems (DRIS): Support to a community-based planning process in the development of formal provider networks in five rural sites (Imperial, Ridgecrest, Lompoc, Humboldt, and Siskiyou).		3-year grant received from Irvine Foundation. RH Programs Liaison is member of Advisory Council.
• Telehealth/Telemedicine Coordination Planning Project		RH Programs Liaison was a member of committee that produced a Report in January 1997 with multiple recommendations. Liaison is now a member of the Steering Committee for the CA Telehealth/Telemedicine Center funded by private foundations.
12. Merger of some OSHPD functions with RHPC staff to avoid duplication.		Completed.
13. Consolidated OSHPD's HELP line with RHPC Office.		Completed and operating for callers in CA. See "Toll-free number" in Item 8.
	14. Information Services function:	
	• *"Newscast"*	Newsletter published at least 8 times per year and distributed currently to approximately 1,600 constituents.

I. STATE LEADERSHIP THROUGH INTERAGENCY COLLABORATION

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
	• *Website/RHPC Homepage*	Designed and operating. Is home to a funding clearinghouse, employment clearinghouse, and links to many rural health resources, other states and other useful information.
	• *Legislative briefings*	Conducted several briefings on RHPC activities and issues for legislative, district office, Rural Caucus members and staff. Submitted Report on Rural Health to the Legislature as required by Ch. 305/AB 911 on May 1, 1996.
	• *Reference library: Establish and maintain hard copy at RHPC Office and an electronic library as part of the RHPC homepage.*	Hard copy library started at RHPC Office; electronically available information is linked on RHPC Website.
	• *State Resource Directory: Create and publish (electronic and hard copy) a resource directory of state and federal information and referral.*	IRHCC project for 1998; exploring feasibility of each department's links and data for state resources. Federal sources being linked to RHPC Website.
	15. Policy Issue Coordination function:	
	• *Constituent Issue/Service Request Tracking*	RHPC Office designed and established an ongoing system to identify and track issues raised from public hearings, letters or other means. IRHCC designed a process for each department to respond to issues.

I. STATE LEADERSHIP THROUGH INTERAGENCY COLLABORATION

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
	16. Surplus Equipment Clearinghouse Website	RHPC Constituent Survey indicated interest in having ability to find and exchange surplus equipment. In order not to duplicate efforts, the RHPC Office supports efforts by the CSRHA and ACHD.
	17. Develop assistance broker function:	
	• *Promote training of clinic CEO's, CFO's and Board Members.*	RH Programs Liaison participated on training panels for clinics in November 1997 and in January 1998.
	• *Support efforts for communities to organize regional transportation networks.*	RH Programs Liaison facilitated problem solving for Trinity HCTF, so that existing transportation services would serve each other's customers across programs.
	• *Develop list of resources to assist with grant writing.*	RHPC Office designed and maintains a Funding Clearinghouse on RHPC Website including pages specific to rural health funding opportunities and resources.
	• *Co-sponsor meetings and seminars to increase public and private rural health communication and information.*	RHPC partnered and co-located meetings with statewide associations including CSAC, CHA, and CSRHA.

II. FUNDING AND REIMBURSEMENT

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
1. DHS is examining reimbursement rates for SNFs within acute care hospitals, for rural clinics and rural safety net providers.		DHS is working with the industry and has formed a Task Force to explore the entire rate setting methodology for long-term care. Also, recent federal law changes to rates are being analyzed for impact on rural clinics and rural safety net providers.
2. HPSA designation for PL 95-210 clinics: DHS working with federal agency on method for computing FTE for physicians.		Federal "draft" regulations were due out in 5/97 and are now due for release in 5/98.
	3. Rural Health Service Small Grants/ Rural Hospital Grants	FY 1996-97: Awarded 78 rural grants consisting of $1.5M for collaboratives; $1.0M for small grants; and, $2.5M for hospitals. FY 1997-98: Awarded 101 rural grants consisting of $1.37M in small grants; and $528,990 for hospitals. FY 1998-99: Proposed at $2M in Governor's Budget.
	4. AB 1126 Healthy Families: Rural Demonstration Projects	RHPC is participating in design process with CMSP, MRMIB, and DHS. To gather input from rural communities, public meetings were held in Sacramento, Redding, Fresno and San Diego.
	5. Establish and maintain a Website page on funding source linkages.	Designed and completed an RHPC Website which includes a "Funding Clearinghouse" with linkages to many federal, state and private sources.

II. FUNDING AND REIMBURSEMENT

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
	6. *Monitor impact of phase out of cost based reimbursement for RHC and FQHCs.*	Reductions in reimbursement commence in FFY 2000 (October 1999).
	7. *RHPC is participating in collaboration with a public/private funders' consortium, including CA Endowment, CA Foundation and James Irvine Foundation, in effort to coordinate resources for rural health projects.*	RHPC and RH Programs Liaison co-sponsored two meetings in 1997; funders agreed to support RHPC Website clearinghouse (Item 5 above), and agreed to meeting in 1998 and to expand inclusion to community foundations.
	8. *Co-sponsor training sessions for providers on funding and financing issues.*	RH Programs Liaison participated in conference for counties and providers; facilitated breakout sessions in 5 rural communities.

III. DATA SYSTEMS

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
1. RHPC staff working with OSHPD on data "template" to be used by rural hospitals for planning and networking.		Analysis completed with CHA. Template being tested by rural hospitals in FY 97-98 and will be updated for next year, based on findings.
2. Discussions among UCSF, OSHPD, and DHS on birth outcomes research for future planning use.		Discussions completed. Linked data bases on birth discharges now available at OSHPD, & data can be obtained at ZIP code level for analysis in rural areas.

IV. AVAILABILITY AND ACCESSIBILITY OF WORKFORCE SERVICES

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
1. (a). RH Programs Liaison, DHS and OSHDP participated in CA Telehealth/Telemedicine Coordination Planning Project to focus on rural areas and publish a report.		Report published in January 1997; committee disbanded. CA Telehealth and Telemedicine Center established in July 1997 with grant from James Irvine Foundation. RH Programs Liaison is member of Center's Steering Committee.
	(b). Universal Service Order: FCC subsidies for telecommunications and Internet access for rural areas (new federal legislation).	RHPC Office working with CA TH/TM Center to alert the rural health field about new FCC funding available for rural sites through recent federal legislation. Articles included in RHPC newsletter.
2. Teleconferencing equipment installed in 12 small counties. Grand rounds being offered in rural areas through teleconferencing.		Teleconferencing equipment installed under a federal grant, ending 4/98. Continuation of phone line funding will depend on each county. Grand rounds to be continued by satellite system through CDC-Atlanta.
3. Research initiated with UCD by DHS and OSHPD on obstetrical services in rural hospitals with telemedicine linkages.		Project between UCD and Colusa Community Hospital resulted in 70% of the county births being delivered in Colusa County, up from 0%. Grants now available through CA TH/TM Center for rural telemedicine purchases.

IV. AVAILABILITY AND ACCESSIBILITY OF WORKFORCE SERVICES

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
4. Rural Recruitment "Jobs Available" Website created and maintained.		Interactive, searchable Website designed, completed, operational and linked to 44 other states. Approximately 400 job vacancies posted; approximately 300 jobs filled. Currently holds 315 job postings, and Website received approximately 5,000 "hits" in 1997.
	5. Participated with CPCC Workforce Development Project.	Continuing; grant not yet funded. RH Programs Liaison is a member of the Steering Committee.
	6. Participated in Rural Technology Seminar (RTS) with CA Rural Development Council (CRDC)	Completed. RHPC partnered with CRDC for RTS Conference held in May 1997 in conjunction with Government Technology Conference; partnering with RCRC for a 2nd Annual RTS in May 1998. RH Programs Liaison is member of planning committee.

V. NETWORK DEVELOPMENT AND MANAGED CARE

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
1. (a) Technical Assistance Center created by OSHPD through June 1996 with federal grant. Support provided to hospital-based networks in So. Humboldt, Intermountain and Tahoe/Forest.		Federal EACH/RPCH Program ended.
1. (b) RH Programs Liaison participated in discussions with CA Health Collaborative to continue technical assistance funding after federal grant ends.		Completed discussions; funding not continued.
2. OSHPD, with RHPC, is helping with network development in Inyo County and Catalina Island.		Efforts completed.
	3. RH Programs Liaison assisted with network development in No. Sierra Rural Health Network and CHA.	Completed; $577,000, 3-year Rural Network Development Project grant received on 10/1/97 from federal Office of Rural Heath Policy.
	4. Study impact of Medi-Cal managed care on rural providers.	Included in Workplan adopted by the RHPC.
	5. Study local HMO product development	RH Programs Liaison participating in DRIS local project development (see "State Leadership" Item 11.) Also participating with CSHRA in feasibility of an FSR to develop a statewide rural non-profit HMO.

VI. STATE REGULATION AND PROCEDURES FACILITATION

1996 REPORT ACTION	ADDITIONAL ACTIONS	CURRENT STATUS
1. Facilitated discussion and adoption of "rural" definition for purposes of rural areas and providers participating in a consolidated license for acute care hospitals in non-rural areas.		Completed.
2. Joint task force to study feasibility of establishing an alternate licensing category for rural general acute care hospitals being designated as a Freestanding Emergency Department.		Completed. Rural General Acute Care Hospital category established.
3. Facilitated discussions among EMSA, DHS and OSHPD on new regulations for EMTs in small and rural hospitals (SB 422).		Completed and implemented.
	4. Facilitated discussions on problematic state regulations, processes and procedures, audits, licensing and certification, facilities, financing, etc. with numerous providers.	Completed issues raised during 1996 and 1997; ongoing.
	5. Facilitated resolution of inquiries on geographic status of rural communities under MSSA, MUA, MUP and HPSA designations. Also definitions for: • *RHPC service small grants* • *FCC Universal Service subsidies* • *CA Health Manpower Policy Commission*	Ongoing; responded to various inquiries from providers on how their sites are classified under different definitions of "rural."

NEXT STEPS

- **1998 Vision, Mission, and Project Workplan**

  The Policy Council has adopted a Vision, Mission, and Project Workplan for rural health in California. The Project Workplan addresses the highest priority problems facing the rural health field today, as determined by public hearing testimony and other input solicited by the Policy Council. To the extent possible in the coming months, the workplan topics will be addressed by the Coordinating Committee through individual action plans.

  The Policy Council will publish Part II of this *1998 Report: Future Actions*, which will include the individual project action plans, selected issue papers, and performance measures. These future actions will be undertaken with the help of the many rural health constituents in the State, and in the same cooperative spirit established in the first two years of Policy Council activity.

Rural Health Policy Council
Vision, Mission, and Major Issue Areas

(Adopted December 1997)

VISION

Residents of rural communities in California will experience improved health status through planned improvements to their local delivery systems for health care and prevention services.

MISSION

The Rural Health Policy Council will advance this vision by ensuring that its State agencies continue to improve communication and cooperation with one another, working in a team approach with rural communities to address the health care issues they face.

Furthermore, the Rural Health Policy Council envisions an ideal rural health care delivery system of the future as:

- fully integrating locally defined health and prevention related services;
- maintaining broad community involvement, collaboration, and acceptance; and,
- using effective strategic local planning, which focuses on measurable outcomes that seek continuous improvement to the overall health status of the entire community.

The Rural Health Policy Council will support communities in designing, developing and achieving their goals by promoting responsive, supportive and timely actions by State agencies, the Legislature, counties, statewide organizations and private foundations. This support could take many forms, by:

- providing expertise, data and technical assistance to rural providers in planning, developing and implementing successful health care delivery systems;
- discussing and redrafting State regulations that may hinder rural providers from delivering the most efficient and appropriate services to their communities;
- streamlining State funding and administrative processes; and,
- working with other public and private funders to assure that resources are targeted in the most efficient and least duplicative ways, and that the gaps in services are filled to the greatest extent possible.

MAJOR ISSUE AREAS:

- Standardization and Consolidation
- Network Development/Integrated Delivery Systems
- Regulation
- Medi-Cal Managed Care (primary, mental health, alcohol & drug)
- Funding
- Technology
- Program-specific Reviews
- Outcome-based State Management
- Strategic Planning for Local Communities
- Transportation
- Communication
- Workforce Availability

Rural Health Policy Council
Project Workplan Outline

Issue Area/Topics	Suggested Tasks
Standardization and Consolidation	
a. Statistical Reporting b. Billing & Financial Reporting c. Audits d. Contracts e. Budgets	a. review existing systems b. identify gaps and overlaps c. identify opportunities to consolidate across departments d. make changes to existing laws, regulations and administrative policy where possible e. implement changes f. provide training to providers
Network Development/Integrated Delivery Systems	
a. Implement Healthy Families/Rural Demo Project b. Study efforts to build integrated systems c. Study issue of statewide rural HMO models	a. work with DHS on criteria, selection and development of 5 rural demos b. track current efforts to integrate rural health systems c. recommend potential models.
Regulation	
a. Speed up appeal process b. Provide consistent interpretation c. Eliminate unnecessary regulations d. Allow flexibility for admin regs in rural areas	a. develop increased understanding of rural areas b. identify from public input the specific regulations that cause problems c. provide interpretation d. change regulations, where possible.
Medi-Cal Managed Care	
a. Assess impact of Medi-Cal Managed Care projects on rural providers	a. review results of quality and system "report cards", other databases b. develop "impact" indicators c. track and monitor indicators d. identify potential models.
Funding	
a. Provide for capital outlay grants b. Categorical grant policies: consolidate & regionalize, provide flexibility, change allowable administrative costs, distinguish rural from urban, shift savings to preventative care c. Study impact of changes to reimbursement policies on rural clinics d. Review results of Rural Service Grants/Rural Hospital programs; make recommendations for third year.	a. study existing methods b. develop alternatives c. adopt alternative and make necessary law and regulation changes where possible

Issue Area/Topics	Suggested Tasks
Technology	
a. Teleconferencing b. Telemedicine/telehealth c. Centralized data information systems d. Technology plans e. Community/county outcome measures	a. identify existing data sites b. consolidate/coordinate existing projects c. conduct data needs/gap analysis d. identify cost savings e. conduct pilots f. make recommendations based on pilots
Program-specific Reviews	
a. Tobacco control programs	a. review current policy impact on rural counties, make recommendations.
Outcome-based State Management	
a. Healthy People 2010 objectives	a. review of proposed objectives for rural impact on reporting, meeting goals, etc.
Transportation	
a. Support innovative efforts to improve patient transportation: – local community – rural to urban/suburban settings – rural EMS care	a. identify areas with successful systems b. identify communities with a need c. identify funding and people manpower resources d. conduct pilot project in a few communities with need e. make recommendations
Strategic Planning for Local Communities	
	a. identify communities who desire strategic planning b. identify state support and technical assistance c. select best processes & existing successful models d. make available plans to communities who want to participate
Communication	
a. Networking - federal, state and local b. Education and training support to rural areas	a. identify areas where communication is lacking or where there is misunderstanding b. identify existing successful models c. develop TA funding sources and ongoing training model.
Workforce Availability	
a. Recruitment and retention	a. identify existing program results b. “get the word out” to providers, work closely with schools and other training providers c. identify laws, regulations, and administrative policy that impede recruitment and retention.

APPENDICES

1. **AB 911 (Chapter 305/1995) Legislation Excerpts**

2. **Member Departments: Interdepartmental Rural Health Coordinating Committee**

3. **List of Acronyms**

Assembly Bill No. 911

CHAPTER 305

An act to amend Sections 11818, 11987.3, and 11987.5 of, to add Chapter 3.4 (commencing with Section 11758.40) to Part 1 of Division 10.5 of, and to add Part 5 (commencing with Section 1179) to Division 1 of, the Health and Safety Code, to amend Sections 4112, 4681.1, 14021, 14105, 14132.06, 14132.44, 14132.47, and 14161 of, to add Sections 7353, 10743.5, 14021.6, 14087.325, 14132.22, and 14132.90 to, to add and repeal Section 14105.981 of, and to add Article 4.1 (commencing with Section 14139.7) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to human services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor August 3, 1995. Filed with Secretary of State August 3, 1995.]

LEGISLATIVE COUNSEL'S DIGEST

AB 911, Vasconcellos. Health services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. Existing law provides for county operated alcohol and drug programs administered by the State Department of Alcohol and Drug Programs.

Existing law establishes the method of reimbursing providers for drug abuse services and alcohol program services under the Medi-Cal program.

This bill would permit the State Department of Alcohol and Drug Programs to enter into a Medi-Cal Drug Treatment Program contract with each county to fund alcohol and drug abuse program services in accordance with prescribed procedures. It would impose restrictions on the provision of specified Medi-Cal drug treatment benefits.

The bill would also revise the method of determining the maximum allowable rate for reimbursement for providers of drug and alcohol rehabilitation services.

Existing law requires the State Department of Health Services to implement a program to remedy deficiencies in health services in rural areas. Existing law also requires the Office of Statewide Health Planning and Development, in conjunction with the State Department of Health Services, to act as the coordinating agency to develop a strategic plan that would assist rural California to prepare for health care reform.

This bill would require the Secretary of the Health and Welfare Agency to establish an Office of Rural Health, or an alternative organizational structure, in one of the departments of the Health and Welfare Agency, to promote a strong working relationship between the state and various entities, as well as to develop health initiatives and maximize the use of existing resources without duplicating existing effort. It would set forth specific efforts that could be undertaken by the office or alternative organizational structure, to the extent that funds are appropriated by the Legislature.

The bill would also require the Health and Welfare Agency to establish an interdepartmental task force to review and direct the activities of the office or alternative organizational structure and to develop a strategic plan for rural health. It would also require the Secretary of the Health and Welfare Agency, by May 1, 1996, to report to the chairs of specified committees and submit the strategic plan.

Existing law provides for various state hospitals under the jurisdiction of the State Department of Mental Health.

This bill would require that department to pay the premium for third-party health coverage for Medicare beneficiaries who are patients in these hospitals. It would continuously appropriate from the General Fund to the department the amount necessary to pay these premiums.

The bill would require the department, if General Fund expenditures under this requirement in any fiscal year, exceed Medicare payments to the department deposited in the General Fund, to report specified information to the Joint Legislative Budget Committee and the Department of Finance.

Existing law requires the State Department of Developmental Services to establish annually reimbursement rates for developmental services, including reimbursement rates for out-of-home care, with these rates to be reviewed by the State Council on Developmental Disabilities.

Existing law requires that, in establishing reimbursement rates for out-of-home care services, one of the cost elements to be included is an adequate amount to be paid to facilities for the basic living needs of a person with developmental disabilities. The department is required to make a redetermination of basic living costs every 3 years, with the first report to be made on March 1, 1996, contingent upon the availability of funds, and if sufficient funds are not available, by March 1, 1997.

This bill would, instead, require that the first report be made by March 1, 1999.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

The people of the State of California do enact as follows:

SECTION 1. Part 5 (commencing with Section 1179) is added to Division 1 of the Health and Safety Code, to read:

PART 5. OFFICE OF RURAL HEALTH

1179. The Legislature finds and declares all of the following:

(a) Outside of California's four major metropolitan areas, the majority of the state is rural. In general, the rural population is older, sicker, poorer, and more likely to be unemployed, uninsured, or underinsured. The lack of primary care, specialty providers and transportation continue to be significant barriers to access to health services in rural areas.

(b) There is no coordinated or comprehensive plan of action for rural health care in California to ensure the health of California's rural residents. Most of the interventions that have taken place on behalf of rural communities have been limited in scope and purpose and were not conceived or implemented with any comprehensive or systematic approach in mind. Because health planning tends to focus on approaches for population centers, the unique needs of rural communities may not be addressed. A comprehensive plan and approach is necessary to obtain federal support and relief, as well as to realistically institute state and industry interventions.

(c) Rural communities lack the resources to make the transition from present practices to managed care, and to make other changes that may be necessary as the result of health care reform efforts. With numerous health care reform proposals being debated and with the extensive changes in the current health care delivery system, a comprehensive and coordinated analysis must take place regarding the impact of these proposals on rural areas.

(d) Rural areas lack the technical expertise and resources to improve and coordinate their local data collection activities, which are necessary for well-targeted health planning, program development, and resource development. Data must be available to local communities to enable them to plan effectively.

(e) The Legislature recognizes the need to take a comprehensive approach to strengthen and coordinate rural health programs and health care delivery systems in order to:

(1) Facilitate access to high quality health care for California's rural communities.

(2) Promote coordinated planning and policy development among state departments and between the State and local public and private providers.

1179.1. (a) The Secretary of the Health and Welfare Agency shall establish an Office of Rural Health, or an alternative organizational structure, in one of the departments of the Health and Welfare

Agency to promote a strong working relationship between state government and local and federal agencies, universities, private and public interest groups, rural consumers, health care providers, foundations, and other offices of rural health, as well as to develop health initiatives and maximize the use of existing resources without duplicating existing effort. The office or alternative organizational structure shall serve as a key information and referral source to promote coordinated planning for the delivery of health services in rural California.

(b) To the extent funds are appropriated by the Legislature, these efforts may include:

(1) Educating the public and recommending appropriate public policies regarding the viability of rural health care in California.

(2) Monitoring and working with state and federal agencies to assess the impact of proposed rules and regulations on rural areas.

(3) Promoting community involvement and community support in maintaining, rebuilding, and diversifying local health services in rural areas.

(4) Encouraging and evaluating the use of advanced communications technology to provide access to health promotion and disease prevention information, specialty expertise, clinical consultation, and continuing education for health professionals.

(5) Encouraging the development of regional health care and public health networks and collaborative efforts, including, but not limited to, emergency transportation networks.

(6) Working with state and local agencies, universities, and private and public interest groups to promote research on rural health issues.

(7) Soliciting the assistance of other offices or programs of rural health in California to carry out the duties of this part.

(8) Disseminating information and providing technical assistance to communities, health care providers, and consumers of health care services.

(9) Promoting strategies to improve health care professional recruitment and retention in rural areas.

(10) Encouraging innovative responses by public and private entities to address rural health issues.

1179.2. (a) The Health and Welfare Agency shall establish an interdepartmental Task Force on Rural Health to coordinate rural health policy development and program operations and to develop a strategic plan for rural health.

(b) At a minimum, the following state departmental directors, or their representatives, shall participate on this task force:

(1) The Director of Health Services.

(2) The Director of Statewide Health Planning and Development.

(3) The Director of Alcohol and Drug Programs.

(4) The Director of the Emergency Medical Services Authority.

(5) The Director of Mental Health.

(c) The task force shall review and direct the activities of the Office of Rural Health or the alternative organizational structure, as determined by the Secretary of the Health and Welfare Agency.

(d) The task force shall establish appropriate mechanisms, such as ad hoc or standing advisory committees or the holding of public hearings in rural communities for the purpose of soliciting and receiving input from these communities, including input from rural hospitals, rural clinics, health care service plans, local governments, academia, and consumers.

(e) By May 1, 1996, the Secretary of the Health and Welfare Agency shall report to the Chair of the Joint Legislative Budget Committee and the Chairs of the Senate and Assembly Health Committees, and at that time submit the strategic plan developed by the task force. This strategic plan may include but shall not be limited to the following elements:

(1) The status of establishing an Office of Rural Health or alternative organizational structure.

(2) The roles and responsibilities of that office or alternative organizational structure.

(3) The mechanism for ongoing input to the office or alternative organizational structure by members of the public, rural health care providers, rural hospitals, health care service plans, and local governments.

(4) The identification of all departments and agencies with significant program or funding responsibility for rural health care.

(5) A detailed plan to consolidate and coordinate the activities of the programs identified pursuant to paragraph (4) to better meet the health care needs of rural residents.

SEC. 2. Chapter 3.4 (commencing with Section 11758.40) of Part 1 of Division 10.5 is added to the Health and Safety Code, to read:

CHAPTER 3.4. MEDI-CAL DRUG TREATMENT PROGRAM

11758.40. Notwithstanding subdivision (c) of Section 11758.12 and subdivision (c) of Section 11758.23, the department may enter into a Medi-Cal Drug Treatment Program contract with each county for the provision of services within the county service area.

11758.43. To the extent any county refuses to execute the Medi-Cal Drug Treatment Program contract in accordance with the requirements of federal medicaid and state Medi-Cal laws, and in accordance with the federal court order and any future action in the case of Sobky v. Smoley, 855 F. Supp. 1123 (E. D. Cal.), the department shall contract directly with the certified providers in that county, and retain that portion of that county's state General Fund allocation necessary to meet the cost of providing services to eligible

Appendix 2

Member Departments:
Interdepartmental Rural Health Coordinating Committee

State agencies currently represented include:

- Department of Health Services:
  - Audits and Investigations
  - Health Information and Strategic Planning
  - Licensing and Certification
  - Medi-Cal Policy
  - Office of County Health Services
  - Primary Care and Family Health

- Office of Statewide Health Planning and Development:
  - California Health Information for Policy Project
  - Cal-Mortgage Loan Insurance Division
  - Facilities Development Division
  - Primary Care Resources and Community Development Division

- Department of Alcohol and Drug Programs

- Emergency Medical Services Authority

- Department of Mental Health:
  - Technical Assistance and Training

- Department of Community Services and Development:
  - Farm Worker and Community Services Programs

Representation is determined by the department directors of the Rural Health Policy Council, and may include representatives of State departments, in addition to the RHPC departments, that wish to participate.

Appendix 3

List of Acronyms

3R-Net	(National) Rural Recruitment and Retention Network
ACHD	Association of California Healthcare Districts
ADP	Department of Alcohol and Drug Programs
BCP	Budget Change Proposal
CA	California
CDC	Centers for Disease Control
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHA	California Healthcare Association
CHEAC	County Health Executive Association of California
CMSP	County Medical Services Program
CPCC	California Primary Care Consortia
CRDC	California Rural Development Council
CSAC	California State Association of Counties
CSRHA	California State Rural Health Association
DDS	Department of Developmental Services
DHS	Department of Health Services
DMH	Department of Mental Health
DRIS	Developing Rural Integrated Systems
EACH/RPCH	Essential Access Care Hospital/Rural Primary Care Hospital
EMSA	Emergency Medical Services Authority
EMT	Emergency Medical Technician
FCC	Federal Communications Commission
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
FSR	Feasibility study report
FTE	Full time equivalent
HCTF	(Trinity County) Health Care Task Force
HMO	Health Maintenance Organization
HPSA	Health Professional Study Area
HWA	Health and Welfare Agency
IRHCC	Interdepartmental Rural Health Coordinating Committee
MRMIB	Managed Risk Medical Insurance Board

MSSA	Medical Service Study Area
MUA	Medically Underserved Areas
MUP	Medically Underserved Population
OSHPD	Office of Statewide Health Planning and Development
PL	Public Law
RCRC	Regional Council of Rural Counties
RHPC	Rural Health Policy Council
SNF	Skilled Nursing Facility
TH/TM	Telehealth/Telemedicine
UCD	University of California, Davis
UCSF	University of California, San Francisco